Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $6,848.85 for date of service, 03/30/01.

   b. The request was received on 03/22/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial Submission of TWCC-60
      1. UB-92s
      2. EOB(s)
   b. Additional documentation received on 05/10/02
      1. Position Statement
      2. Medical Records
      3. UB-92
      4. EOBs
      5. EOBs from other carriers
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. Medical Audit summary/EOB/TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/21/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 05/21/02. The response from the insurance carrier was received in the Division on 06/03/02. Based on 133.307 (i) the insurance carrier's response is timely

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/09/02
   "The Carrier failed to provide an adequate response to the request for reconsideration. Based upon the initial denial presented by the Carrier, it is the requestor's position that the Carrier is required to pay the entire amount in dispute. In addition, the Carrier did not reference the incorrect application if code 'M' to fee codes in the initial MDR response."

2. Respondent: Letter dated 05/30/02
   "The requester provides no rationale why billing its usual and customary fee for this procedure is fair and reasonable and appears to be implying that usual and customary is the same as fair and reasonable. If that were the case then the legislature would have used that as the basis for determining an appropriate amount in the absence of a MAR and used that wording instead in Section 413.011 (b). To be sure, billing usual and customary without any discussion of how this may be fair and reasonable is, itself, neither fair nor reasonable."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/30/01.

2. The provider billed a total of $10,204.85 on the date of service in dispute.

3. The carrier reimbursed a total of $517.00, with an additional payment of $299.00 issued on 06/05/02 (check # 08528126), and denied additional reimbursement as "M – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM."

4. After payment of the additional $299.00, the amount in dispute appears to be $6,549.85.

5. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401(a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011(b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. Regardless of the carrier's methodology or lack thereof, or a timely or untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted EOB(s) from other carriers that indicate those carriers paid varying percentages of the billed charges. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(b) of the Texas Labor Code.

The above Findings and Decision are hereby issued this 13th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt